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THE GENERAL ASSEMBLY OF PENNSYLVANIA

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**SENATE BILL**

**No. 1393** Session of  
2008

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INTRODUCED BY HUGHES, MUSTO, KITCHEN, C. WILLIAMS AND KASUNIC,  
MAY 7, 2008

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REFERRED TO PUBLIC HEALTH AND WELFARE, MAY 7, 2008

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AN ACT

1 Amending the act of June 13, 1967 (P.L.31, No.21), entitled "An  
2 act to consolidate, editorially revise, and codify the public  
3 welfare laws of the Commonwealth," further providing for  
4 medical assistance payments for institutional care, for  
5 additional services for eligible persons other than the  
6 medically needy; providing for payments for readmissions to a  
7 hospital paid through diagnosis-related groups and for  
8 maximum payment to practitioners for inpatient  
9 hospitalization; further providing for time periods;  
10 providing for hospital assessments; further providing for  
11 third-party liability and for data matching; and providing  
12 for Federal law recovery of medical assistance reimbursement.

13 The General Assembly of the Commonwealth of Pennsylvania  
14 hereby enacts as follows:

15 Section 1. Section 443.1(7) of the act of June 13, 1967  
16 (P.L.31, No.21), known as the Public Welfare Code, is amended by  
17 adding a subclause to read:

18 Section 443.1. Medical Assistance Payments for Institutional  
19 Care.--The following medical assistance payments shall be made  
20 in behalf of eligible persons whose institutional care is  
21 prescribed by physicians:

22 \* \* \*

1 (7) After June 30, 2007, payments to county and nonpublic  
2 nursing facilities enrolled in the medical assistance program as  
3 providers of nursing facility services shall be determined in  
4 accordance with the methodologies for establishing payment rates  
5 for county and nonpublic nursing facilities specified in the  
6 department's regulations and the Commonwealth's approved Title  
7 XIX State Plan for nursing facility services in effect after  
8 June 30, 2007. The following shall apply:

9 \* \* \*

10 (i.1) During the period of July 1, 2008, through June 30,  
11 2011, the department shall apply a revenue adjustment neutrality  
12 factor and make adjustments to county and nonpublic nursing  
13 facility payment rates for medical assistance nursing facility  
14 services in each fiscal year. The revenue adjustment neutrality  
15 factor for each fiscal year shall limit the estimated Statewide  
16 day-weighted average payment rate for that fiscal year so that  
17 the aggregate increase in the Statewide day-weighted average  
18 payment rate over the period commencing July 1, 2005, and ending  
19 June 30 of the fiscal year in which the factor is applied does  
20 not exceed the percentage rate of increase permitted by the  
21 funds appropriated for nursing facility services in the General  
22 Appropriations Acts for those fiscal years. Application of the  
23 revenue adjustment neutrality factor shall be subject to Federal  
24 approval of any amendments as may be necessary to the  
25 Commonwealth's approved Title XIX State Plan for nursing  
26 facility services.

27 \* \* \*

28 Section 2. Section 443.4 of the act, amended November 28,  
29 1973 (P.L.364, No.128), is amended to read:

30 Section 443.4. Additional Services for Eligible Persons

1 [Other Than the Medically Needy].--[Except for the medically  
2 needy, persons] Persons eligible for medical assistance may,  
3 pursuant to regulations of the department, also receive dental  
4 services, vision care provided by a physician skilled in  
5 diseases of the eye or by an optometrist, prescribed  
6 medications, prosthetics and appliances, ambulance  
7 transportation, skilled nursing home care for an unlimited  
8 period of time, and other remedial, palliative or therapeutic  
9 services prescribed by or provided under the direction of a  
10 physician or podiatrist.

11 Section 3. The act is amended by adding sections to read:

12 Section 443.9. Payments for Readmission to a Hospital Paid  
13 Through Diagnosis-Related Groups.--All of the following shall  
14 apply to eligible recipients readmitted to a hospital within  
15 fourteen days of the date of discharge:

16 (1) If the readmission is for the treatment of conditions  
17 that could or should have been treated during the previous  
18 admission, the department shall make no payment in addition to  
19 the hospital's original diagnosis-related group payment. If the  
20 combined hospital stay qualifies as an outlier, as set forth  
21 under the department's regulations, an outlier payment shall be  
22 made.

23 (2) If the readmission is due to complications of the  
24 original diagnosis and the result is a different diagnosis-  
25 related group with a higher payment, the department shall pay  
26 the higher diagnosis-related group payment rather than the  
27 original diagnosis-related group payment.

28 (3) If the readmission is due to conditions unrelated to the  
29 previous admission, the department shall consider the  
30 readmission as a new admission for payment purposes.

1       Section 443.10. Maximum Payment to Practitioners for  
2 Inpatient Hospitalization.--The maximum payment made to a  
3 practitioner for all services provided to an eligible recipient  
4 during any one period of inpatient hospitalization shall be the  
5 lowest of the following:

6       (1) The practitioner's usual charge to the general public  
7 for the same service.

8       (2) The medical assistance maximum allowable fee for the  
9 service.

10       (3) A maximum payment limit, per recipient per the period of  
11 inpatient hospitalization, established by the medical assistance  
12 program and published as a notice in the Pennsylvania Bulletin.  
13 If the fee for the actual service exceeds the maximum payment  
14 limit, the fee for the actual procedure shall be the maximum  
15 payment for the period of inpatient hospitalization.

16       Section 4. Section 811-B of the act, added July 4, 2004  
17 (P.L.528, No.69), is amended to read:

18 Section 811-B. Time periods.

19       The assessment authorized in this article shall not be  
20 imposed or paid prior to July 1, 2004, or in the absence of  
21 Federal financial participation as described in section 803-B.  
22 The assessment shall cease on June 30, [2008] 2013, or earlier  
23 if required by law.

24       Section 5. Section 811-C of the act, amended November 29,  
25 2004 (P.L.1272, No.154), is amended to read:

26 Section 811-C. Time periods.

27       [The assessment authorized in this article shall not be  
28 imposed prior to July 1, 2003, for private ICFs/MR and July 1,  
29 2004, for public ICFs/MR and shall cease on June 30, 2009, or  
30 earlier if required by law.]

1 (a) Imposition.--The assessment authorized under this  
2 article shall not be imposed as follows:

3 (1) Prior to July 1, 2003, for private ICFs/MR.

4 (2) Prior to July 1, 2004, for public ICFs/MR.

5 (3) In the absence of Federal financial participation as  
6 described under section 803-C.

7 (b) Cessation.--The assessment authorized under this article  
8 shall cease June 30, 2013, or earlier, if required by law.

9 Section 6. The act is amended by adding an article to read:

10 ARTICLE VIII-E

11 HOSPITAL ASSESSMENTS

12 Section 801-E. Definitions.

13 The following words and phrases when used in this article  
14 shall have the meanings given to them in this section unless the  
15 context clearly indicates otherwise:

16 "Assessment." The fee authorized to be implemented under  
17 this article on every general acute care hospital within a  
18 municipality.

19 "Exempt hospital." A hospital that the Secretary of Public  
20 Welfare has determined meets one of the following:

21 (1) Is excluded under 42 C.F.R. § 412.23(a), (b), (d)  
22 and (f) (relating to excluded hospitals: classification) as  
23 of March 20, 2008, from reimbursement of certain Federal  
24 funds under the prospective payment system.

25 (2) Is a Federal veterans' affairs hospital.

26 (3) Provides care, including inpatient hospital  
27 services, to all patients free of charge.

28 "General acute care hospital." A hospital other than an  
29 exempt hospital.

30 "Hospital." A facility licensed as a hospital under 28 Pa.

1 Code Pt. IV Subpt. B (relating to general and special hospitals)  
2 and located within a municipality.

3 "Municipality." A city of the first class.

4 "Net operating revenue." Gross charges for facilities less  
5 any deducted amounts for bad debts, charity care and payer  
6 discounts as those terms are applied under 42 C.F.R. §  
7 433.68(d)(1)(iii) (relating to permissible health care-related  
8 taxes after the transition period).

9 "Program." The Commonwealth's medical assistance program as  
10 authorized under Article IV.

11 Section 802-E. Authorization.

12 In order to generate additional revenues for the purpose of  
13 assuring that medical assistance recipients have access to  
14 hospital services, and that all citizens have access to  
15 emergency department services, a municipality may, by ordinance,  
16 impose a monetary assessment on the net operating revenue of  
17 each general acute care hospital located in the municipality  
18 subject to the conditions and requirements specified under this  
19 article. The ordinance may include appropriate administrative  
20 provisions including, without limitation, provisions for the  
21 collection of interest and penalties. In each year in which the  
22 assessment is implemented, the assessment shall be subject to  
23 the maximum aggregate amount that may be assessed under 42 CFR §  
24 433.68(f)(3)(i) (relating to permissible health care-related  
25 taxes after the transition period) or any other maximum  
26 established under Federal law.

27 Section 803-E. Implementation.

28 The assessment authorized under this article, once imposed,  
29 shall be implemented as a health-care related fee as defined  
30 under section 1903(w)(3)(B) of the Social Security Act (49 Stat.

1 620, 42 U.S.C. § 1396b(w)(3)(B)) or any amendments thereto and  
2 may be collected only to the extent and for the periods that the  
3 secretary determines that revenues generated by the assessment  
4 will qualify as the State share of program expenditures eligible  
5 for Federal financial participation.

6 Section 804-E. Administration.

7 (a) Remittance.--Upon collection of the funds generated by  
8 the assessment authorized under this article, the municipality  
9 shall remit a portion of the funds to the Commonwealth for the  
10 purposes set forth under section 802-E, except that the  
11 municipality may retain funds in an amount necessary to  
12 reimburse it for its reasonable costs in the administration and  
13 collection of the assessment as set forth in an agreement to be  
14 entered into between the municipality and the Commonwealth  
15 acting through the secretary.

16 (b) Establishment.--There is established a restricted  
17 account in the General Fund for the receipt and deposit of funds  
18 under subsection (a). Funds in the account are hereby  
19 appropriated to the department for purposes of making  
20 supplemental or increased medical assistance payments for  
21 emergency department services to general acute care hospitals  
22 within the municipality and to maintain or increase other  
23 medical assistance payments to general acute care hospitals  
24 within the municipality.

25 Section 805-E. No hold harmless.

26 No general acute care hospital shall be directly guaranteed a  
27 repayment of its assessment in derogation of 42 CFR 433.68(f)  
28 (relating to permissible health care-related taxes after the  
29 transition period), except that in each fiscal year in which an  
30 assessment is implemented, the department shall use a portion of

1 the funds received under section 804-E(a) for the purposes  
2 outlined under section 804-E(b) to the extent permissible under  
3 Federal and State law or regulation and without creating an  
4 indirect guarantee to hold harmless, as those terms are used  
5 under 42 CFR 433.68(f)(i). The secretary shall submit any State  
6 Medicaid plan amendments to the United States Department of  
7 Health and Human Services that are necessary to make the  
8 payments authorized under section 804-E(b).

9 Section 806-E. Federal waiver.

10 To the extent necessary in order to implement this article,  
11 the department shall seek a waiver under 42 CFR 433.68(e)  
12 (relating to permissible health care-related taxes after the  
13 transition period) from the Centers for Medicare and Medicaid  
14 Services of the United States Department of Health and Human  
15 Services.

16 Section 807-E. Tax exemption.

17 Notwithstanding any exemptions granted by any other Federal,  
18 State or local tax or other law, including section 204(a)(3) of  
19 the act of May 22, 1933 (P.L.853, No.155), known as The General  
20 County Assessment Law, no general acute care hospital in the  
21 municipality shall be exempt from the assessment.

22 Section 7. Section 1409 of the act, amended or added July  
23 10, 1980 (P.L.493, No.105), June 16, 1994 (P.L.319, No.49) and  
24 July 7, 2005 (P.L.177, No.42), is amended to read:

25 Section 1409. Third Party Liability.--(a) (1) No person  
26 having private health care coverage shall be entitled to receive  
27 the same health care furnished or paid for by a publicly funded  
28 health care program. For the purposes of this section, "publicly  
29 funded health care program" shall mean care for services  
30 rendered by a State or local government or any facility thereof,

1 health care services for which payment is made under the medical  
2 assistance program established by the department or by its  
3 fiscal intermediary, or by an insurer or organization with which  
4 the department has contracted to furnish such services or to pay  
5 providers who furnish such services. For the purposes of this  
6 section, "privately funded health care" means medical care  
7 coverage contained in accident and health insurance policies or  
8 subscriber contracts issued by health plan corporations and  
9 nonprofit health service plans, certificates issued by fraternal  
10 benefit societies, and also any medical care benefits provided  
11 by self insurance plan including self insurance trust, as  
12 outlined in Pennsylvania insurance laws and related statutes.

13 (2) If such a person receives health care furnished or paid  
14 for by a publicly funded health care program, the insurer of his  
15 private health care coverage shall reimburse the publicly funded  
16 health care program, the cost incurred in rendering such care to  
17 the extent of the benefits provided under the terms of the  
18 policy for the services rendered.

19 (3) Each publicly funded health care program that furnishes  
20 or pays for health care services to a recipient having private  
21 health care coverage shall be entitled to be subrogated to the  
22 rights that such person has against the insurer of such coverage  
23 to the extent of the health care services rendered. Such action  
24 may be brought within five years from the date that service was  
25 rendered such person.

26 (4) When health care services are provided to a person under  
27 this section who at the time the service is provided has any  
28 other contractual or legal entitlement to such services, the  
29 secretary of the department shall have the right to recover from  
30 the person, corporation, or partnership who owes such

1 entitlement, the amount which would have been paid to the person  
2 entitled thereto, or to a third party in his behalf, or the  
3 value of the service actually provided, if the person entitled  
4 thereto was entitled to services. The Attorney General may, to  
5 recover under this section, institute and prosecute legal  
6 proceedings against the person, corporation, health service plan  
7 or fraternal society owing such entitlement in the appropriate  
8 court in the name of the secretary of the department.

9 (5) The Commonwealth of Pennsylvania shall not reimburse any  
10 local government or any facility thereof, under medical  
11 assistance or under any other health program where the  
12 Commonwealth pays part or all of the costs, for care provided to  
13 a person covered under any disability insurance, health  
14 insurance or prepaid health plan.

15 (6) In local programs fully or partially funded by the  
16 Commonwealth, Commonwealth participation shall be reduced in the  
17 amount proportionate to the cost of services provided to a  
18 person.

19 (7) When health care services are provided to a dependent of  
20 a legally responsible relative, including but not limited to a  
21 spouse or a parent of an unemancipated child, such legally  
22 responsible relative shall be liable for the cost of health care  
23 services furnished to the individual on whose behalf the duty of  
24 support is owed. The department shall have the right to recover  
25 from such legally responsible relative the charges for such  
26 services furnished under the medical assistance program.

27 (b) (1) When benefits are provided or will be provided to a  
28 beneficiary under this section because of an injury for which  
29 another person is liable, or for which an insurer is liable in  
30 accordance with the provisions of any policy of insurance issued

1 pursuant to Pennsylvania insurance laws and related statutes the  
2 department shall have the right to recover from such person or  
3 insurer the reasonable value of benefits so provided. The  
4 Attorney General or his designee may, at the request of the  
5 department, to enforce such right, institute and prosecute legal  
6 proceedings against the third person or insurer who may be  
7 liable for the injury in an appropriate court, either in the  
8 name of the department or in the name of the injured person, his  
9 guardian, personal representative, estate or survivors.

10 (2) The department may:

11 (i) compromise, or settle and release any such claims; or

12 (ii) waive any such claim, in whole or in part, or if the  
13 department determines that collection would result in undue  
14 hardship upon the person who suffered the injury, or in a  
15 wrongful death action upon the heirs of the deceased.

16 (3) No action taken in behalf of the department pursuant to  
17 this section or any judgment rendered in such action shall be a  
18 bar to any action upon the claim or cause of action of the  
19 beneficiary, his guardian, personal representative, estate,  
20 dependents or survivors against the third person who may be  
21 liable for the injury, or shall operate to deny to the  
22 beneficiary the recovery for that portion of any damages not  
23 covered hereunder.

24 (4) Where an action is brought by the department pursuant to  
25 this section, it shall be commenced within five years of the  
26 date [the cause of action arises] the department receives notice  
27 that a third party may be liable for the beneficiary's injuries:

28 (i) The death of the beneficiary does not abate any right of  
29 action established by this section.

30 (ii) When an action or claim is brought by persons entitled

1 to bring such actions or assert such claims against a third  
2 party who may be liable for causing the death of a beneficiary,  
3 any settlement, judgment or award obtained is subject to the  
4 department's claims for reimbursement of the benefits provided  
5 to the beneficiary under the medical assistance program.

6 (iii) Where the action or claim is brought by the  
7 beneficiary alone and the beneficiary incurs a personal  
8 liability to pay attorney's fees and costs of litigation, the  
9 department's claim for reimbursement of the benefits provided to  
10 the beneficiary shall be limited to the amount of the medical  
11 expenditures for the services to the beneficiary.

12 (iv) For the purposes of any statute of limitation or  
13 statute of repose, the time during which the department may  
14 commence an action shall be tolled during the minority of the  
15 beneficiary.

16 (5) If either the beneficiary or the department brings an  
17 action or claim against such third party or insurer, the  
18 beneficiary or the department shall within thirty days of filing  
19 the action give to the other written notice by personal service,  
20 or certified or registered mail of the action or claim. Proof of  
21 such notice shall be filed in such action or claim. If an action  
22 or claim is brought by either the department or beneficiary, the  
23 other may, at any time before trial on the facts, become a party  
24 to, or shall consolidate his action or claim with the other if  
25 brought independently. The beneficiary shall include as part of  
26 his claim the amount of benefits that have been or will be  
27 provided by the medical assistance program, unless the  
28 department brings an action or intervenes in an action brought  
29 by the beneficiary.

30 (6) If an action or claim is brought by the department

1 pursuant to subsection (a), written notice to the beneficiary,  
2 guardian, personal representative, estate or survivor given  
3 pursuant to this section shall advise him of his right to  
4 intervene in the proceeding, his right to recover the reasonable  
5 value of the benefits provided.

6 (7) [In] Except as provided under section 1409.1, in the  
7 event of judgment, award or settlement in a suit or claim  
8 against such third party or insurer:

9 (i) If the action or claim is prosecuted by the beneficiary  
10 alone, the court or agency shall first order paid from any  
11 judgment or award the reasonable litigation expenses, as  
12 determined by the court, incurred in preparation and prosecution  
13 of such action or claim, together with reasonable attorney's  
14 fees, when an attorney has been retained. After payment of such  
15 expenses and attorney's fees the court or agency shall, on the  
16 application of the department, allow as a first lien against the  
17 amount of such judgment or award, the amount of the expenditures  
18 for the benefit of the beneficiary under the medical assistance  
19 program.

20 (ii) If the action or claim is prosecuted both by the  
21 beneficiary and the department, the court or agency shall first  
22 order paid from any judgment or award, the reasonable litigation  
23 expenses incurred in preparation and prosecution of such action  
24 or claim, together with reasonable attorney's fees based solely  
25 on the services rendered for the benefit of the beneficiary.  
26 After payment of such expenses and attorney's fees, the court or  
27 agency shall apply out of the balance of such judgment or award  
28 an amount of benefits paid on behalf of the beneficiary under  
29 the medical assistance program reduced by the department's pro  
30 rata share of attorney fees and costs in an amount not to exceed

1 twenty-five percent of the department's claim.

2 (iii) With respect to claims against third parties for the  
3 cost of medical assistance services delivered through a managed  
4 care organization contract, the department shall recover the  
5 actual payment to the hospital or other medical provider for the  
6 service. If no specific payment is identified by the managed  
7 care organization for the service, the department shall recover  
8 its fee schedule amount for the service.

9 (8) [Upon] Except as provided under section 1409.1, upon  
10 application of the department, the court or agency shall allow a  
11 lien against any third party payment or trust fund resulting  
12 from a judgment, award or settlement in the amount of any  
13 expenditures in payment of additional benefits arising out of  
14 the same cause of action or claim provided on behalf of the  
15 beneficiary under the medical assistance program, when such  
16 benefits were provided or became payable subsequent to the date  
17 of the judgment, award or settlement.

18 (9) Unless otherwise directed by the department, no payment  
19 or distribution shall be made to a claimant or a claimant's  
20 designee of the proceeds of any action, claim or settlement  
21 where the department has an interest without first satisfying or  
22 assuring satisfaction of the interest of the Commonwealth. Any  
23 person who, after receiving notice of the department's interest,  
24 knowingly fails to comply with the obligations established under  
25 this clause shall be liable to the department, and the  
26 department may sue to recover from the person.

27 (10) When the department has perfected a lien upon a  
28 judgment or award in favor of a beneficiary against any third  
29 party for an injury for which the beneficiary has received  
30 benefits under the medical assistance program, the department

1 shall be entitled to a writ of execution as lien claimant to  
2 enforce payment of said lien against such third party with  
3 interest and other accruing costs as in the case of other  
4 executions. In the event the amount of such judgment or award so  
5 recovered has been paid to the beneficiary, the department shall  
6 be entitled to a writ of execution against such beneficiary to  
7 the extent of the department's lien, with interest and other  
8 accruing costs as in the cost of other executions.

9 (11) Except as otherwise provided in this act,  
10 notwithstanding any other provision of law, the entire amount of  
11 any settlement of the injured beneficiary's action or claim,  
12 with or without suit, is subject to the department's claim for  
13 reimbursement of the benefits provided any lien filed pursuant  
14 thereto, but in no event shall the department's claim exceed  
15 one-half of the beneficiary's recovery after deducting for  
16 attorney's fees, litigation costs, and medical expenses relating  
17 to the injury paid for by the beneficiary.

18 (12) In the event that the beneficiary, his guardian,  
19 personal representative, estate or survivors or any of them  
20 brings an action against the third person who may be liable for  
21 the injury, notice of institution of legal proceedings, notice  
22 of settlement and all other notices required by this act shall  
23 be given to the secretary (or his designee) in Harrisburg except  
24 in cases where the secretary specifies that notice shall be  
25 given to the Attorney General. Notice of settlement shall be  
26 provided by the beneficiary at least thirty days before the  
27 settlement becomes legally binding upon the parties. All such  
28 notices shall be given by the attorney retained to assert the  
29 beneficiary's claim, or by the injured party beneficiary, his  
30 guardian, personal representative, estate or survivors, if no

1 attorney is retained.

2 (13) The following special definitions apply to this  
3 subsection [(b)]:

4 "Beneficiary" means any person, including a minor, who has  
5 received benefits or will be provided benefits under this act  
6 because of an injury for which another person may be liable. It  
7 includes such beneficiary's guardian, conservator, or other  
8 personal representative, his estate or survivors.

9 "Insurer" includes any insurer as defined in the act of May  
10 17, 1921 (P.L.789, No.285), known as "The Insurance Department  
11 Act of one thousand nine hundred and twenty-one," including any  
12 insurer authorized under the Laws of this Commonwealth to insure  
13 persons against liability or injuries caused to another, and  
14 also any insurer providing benefits under a policy of bodily  
15 injury liability insurance covering liability arising out of  
16 ownership, maintenance or use of a motor vehicle which provides  
17 uninsured motorist endorsement of coverage pursuant to the act  
18 of July 19, 1974 (P.L.489, No.176), known as the "Pennsylvania  
19 No-fault Motor Vehicle Insurance Act."

20 (c) (1) Following notice and hearing, the department may  
21 administratively impose a penalty of up to one thousand dollars  
22 (\$1,000) per violation upon any person who wilfully fails to  
23 comply with the obligations imposed under this section.

24 (2) If a beneficiary fails to comply with the obligations  
25 imposed under this section, the resolution of any action or  
26 claim brought by the beneficiary, whether by verdict or  
27 settlement, shall not extinguish or in any way affect the  
28 department's claim. Notwithstanding the resolution, the  
29 department may bring an action under subsection (b)(1) within  
30 the period provided under subsection (b)(4) or five years from

1 the date of the department's discovery of the verdict or  
2 settlement, whichever is later. In any action by the department  
3 under subsection (b), a prior settlement for monetary damages by  
4 the defendant for an amount in excess of five thousand dollars  
5 (\$5,000) with the injured beneficiary shall be deemed an  
6 admission of liability by the settling defendants,  
7 notwithstanding anything to the contrary in the settlement  
8 agreement, and the only issue shall be the department's damages.

9 Section 8. The act is amended by adding a section to read:

10 Section 1409.1. Federal Law Recovery of Medical Assistance  
11 Reimbursement.--(a) To the extent that Federal law limits the  
12 department's recovery of medical assistance reimbursement to the  
13 medical portion of a beneficiary's judgment, award or settlement  
14 in a claim against a third party, the provisions of this section  
15 shall apply.

16 (b) In the event of judgment, award or settlement in a suit  
17 or claim against a third party or insurer:

18 (1) If the action or claim is prosecuted by the beneficiary  
19 alone, the court or agency shall first order paid from any  
20 judgment or award the reasonable litigation expenses, as  
21 determined by the court, incurred in preparation and prosecution  
22 of the action or claim, together with reasonable attorney fees.  
23 After payment of the expenses and attorney fees, the court or  
24 agency shall allocate the judgment or award between the medical  
25 portion and other damages and shall allow the department a first  
26 lien against the medical portion of the judgment or award, the  
27 amount of the expenditures for the benefit of the beneficiary  
28 under the medical assistance program reduced by the department's  
29 pro rata share of attorney fees and the costs, in an amount not  
30 to exceed twenty-five percent of the department's claim.

1       (2) If the action or claim is prosecuted both by the  
2 beneficiary and the department, the court or agency shall first  
3 order paid from any judgment or award the reasonable litigation  
4 expenses incurred in preparation and prosecution of the action  
5 or claim, together with reasonable attorney fees based solely on  
6 the services rendered for the benefit of the beneficiary. After  
7 payment of the expenses and attorney fees, the court or agency  
8 shall allocate the judgment or award between the medical portion  
9 and other damages and shall make an award to the department out  
10 of the medical portion of the judgment or award the amount of  
11 benefits paid on behalf of the beneficiary under the medical  
12 assistance program.

13       (3) The department shall be given reasonable advance notice  
14 and an opportunity to participate before the court makes any  
15 allocation of a judgment or award under this section.

16       (c) Upon application of the department, the court or agency  
17 shall allow a lien against the medical portion of any third  
18 party payment or trust fund resulting from a judgment, award or  
19 settlement in the amount of any expenditures in payment of  
20 additional benefits arising out of the same cause of action or  
21 claim provided on behalf of the beneficiary under the medical  
22 assistance program, if the benefits were provided or became  
23 payable subsequent to the date of the judgment, award or  
24 settlement.

25       (d) No settlement of a claim in which the department has an  
26 interest shall be valid unless, prior to settling the claim, the  
27 parties jointly notify the department and attempt to determine  
28 by agreement with the department the portion of the settlement  
29 that is due the department as reimbursement for benefits  
30 provided. If a settlement conference or mediation session is

1 held on such a claim by the court or under its auspices, the  
2 department shall be notified and invited to participate. If no  
3 agreement on payment of its claim is reached with the  
4 department, the parties shall notify the department if they  
5 choose to settle the case without the department's agreement and  
6 subject to section 1409(c)(2). Within fifteen days of receipt of  
7 the notice, the department shall send written notice to the  
8 parties and the court indicating that no agreement with the  
9 department has been reached and that the department asserts a  
10 claim against the settlement. Within ten days of the date of  
11 issuance of the letter by the department, any party may either  
12 petition the court in which the action is pending for an  
13 allocation of the settlement or, if no action is pending, file a  
14 request for an allocation hearing with the department's Bureau  
15 of Hearings and Appeals. If no petition or request for hearing  
16 is filed, then the settlement amount shall, as a matter of law,  
17 include the entire amount of the department's claim up to the  
18 amount of the settlement.

19 Section 9. Section 1413 of the act, added July 7, 2005  
20 (P.L.177, No.42), is amended to read:

21 Section 1413. Data Matching.--(a) All entities providing  
22 health insurance or health care coverage to individuals residing  
23 within this Commonwealth shall provide such information on  
24 coverage and benefits, as the department may specify, for any  
25 recipient of medical assistance or child support services  
26 identified by the department by name and either policy number or  
27 Social Security number. The information the department may  
28 specify in its request may include information needed to  
29 determine during what period individuals or their spouses or  
30 their dependents may be or may have been covered by the entity

1 and the nature of the coverage that is or was provided by the  
2 entity, including the name, address and identifying number of  
3 the plan.

4 (b) All entities providing health insurance or health care  
5 coverage to individuals residing within this Commonwealth shall  
6 accept the department's right of recovery and the assignment to  
7 the department of any right of an individual or any other entity  
8 to payment for an item or service for which payment has been  
9 made by the medical assistance program and shall receive,  
10 process and pay claims for reimbursement submitted by the  
11 department or its authorized contractor with respect to medical  
12 assistance recipients who have coverage for such claims.

13 (c) To the maximum extent permitted by Federal law and  
14 notwithstanding any policy or plan provision to the contrary, a  
15 claim by the department for reimbursement of medical assistance  
16 shall be deemed timely filed with the entity providing health  
17 insurance or health care coverage and shall not be denied solely  
18 on the basis of the date of submission of the claim, the type or  
19 format of the claim or a failure to present proper documentation  
20 at the point of sale that is the basis of the claim, if it is  
21 filed as follows:

22 (1) within five years of the date of service for all dates  
23 of service occurring on or before June 30, 2007; or

24 (2) within three years of the date of service for all dates  
25 of service occurring on or after July 1, 2007.

26 (c.1) Any action by the department to enforce its rights  
27 with respect to a claim submitted by the department under this  
28 section must be commenced within six years of the department's  
29 submission of the claim. All entities providing health care  
30 coverage within this Commonwealth shall respond within forty-

1 five days to any inquiry by the department regarding a claim for  
2 payment for any health care item or service that is submitted  
3 not later than three years after the date of provision of the  
4 health care item of service.

5 (d) The department is authorized to enter into agreements  
6 with entities providing health insurance and health care  
7 coverage for the purpose of carrying out the provisions of this  
8 section. The agreement shall provide for the electronic exchange  
9 of data between the parties at a mutually agreed-upon frequency,  
10 but no less frequently than [once every two months] monthly, and  
11 may also allow for payment of a fee by the department to the  
12 entity providing health insurance or health care coverage.

13 (e) Following notice and hearing, the department may impose  
14 a penalty of up to one thousand dollars (\$1,000) per violation  
15 upon any entity that wilfully fails to comply with the  
16 obligations imposed by this section.

17 (e.1) It is a condition of doing business in this  
18 Commonwealth that every entity subject to this section comply  
19 with the provisions of this section and agree not to deny a  
20 claim submitted by the department on the basis of a plan or  
21 contract provision that is inconsistent with subsection (c).

22 (f) This section shall apply to every entity providing  
23 health insurance or health care coverage within this  
24 Commonwealth, including, but not limited to, plans, policies,  
25 contracts or certificates issued by:

26 (1) A stock insurance company incorporated for any of the  
27 purposes set forth in section 202(c) of the act of May 17, 1921  
28 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

29 (2) A mutual insurance company incorporated for any of the  
30 purposes set forth in section 202(d) of "The Insurance Company

1 Law of 1921."

2 (3) A professional health services plan corporation as  
3 defined in 40 Pa.C.S. Ch. 63 (relating to professional health  
4 services plan corporations).

5 (4) A health maintenance organization as defined in the act  
6 of December 29, 1972 (P.L.1701, No.364), known as the "Health  
7 Maintenance Organization Act."

8 (5) A fraternal benefit society as defined in section 2403  
9 of "The Insurance Company Law of 1921."

10 (6) A person who sells or issues contracts or certificates  
11 of insurance which meet the requirements of this act.

12 (7) A hospital plan corporation as defined in 40 Pa.C.S. Ch.  
13 61 (relating to hospital plan corporations).

14 (8) Health care plans subject to the Employee Retirement  
15 Income Security Act of 1974 (Public Law 93-406, 88 Stat. 829),  
16 self-insured plans, service benefit plans, managed care  
17 organizations, pharmacy benefit managers and every other  
18 organization that is, by statute, contract or agreement, legally  
19 responsible for the payment of a claim for a health care service  
20 or item to the maximum extent permitted by Federal law.

21 Section 10. This act shall take effect as follows:

22 (1) The following provisions shall take effect  
23 immediately:

24 (i) The addition of Article VIII-E of the act.

25 (ii) This section.

26 (2) The remainder of the act shall take effect in 60  
27 days.